Lechemanavasagar a/l S Karuppiah v Dr Thomas Yau Pak Chenk & Anor

HIGH COURT (KUALA LUMPUR) — CIVIL SUIT NO S4–22–864 OF 1999
ROHANA YUSUF J
4 OCTOBER 2007

Tort — Negligence — Professional negligence — Medical practitioner — Whether risks of operation explained to patient

Tort — Negligence — Professional negligence — Medical practitioner — Causation — Whether evidence established defendants caused the injury to the plaintiff

Tort — Negligence — Professional negligence — Medical practitioner — Causation — Whether evidence established treatment post-surgery of the defendants caused the lung infection of plaintiff

The plaintiff accidentally swallowed a fish bone. He went to see a general practitioner who advised him to see an Ear, Nose and Throat ('ENT') specialist immediately. One week later the plaintiff went to see the first defendant. An operation to remove the fish bone was performed by the first defendant on the same day. The plaintiff was admitted and was supposedly put on Nil Orally after the operation. The plaintiff was however given tablets orally and given a drink of Milo by the nursing staff of the hospital. Later it was discovered that the plaintiff had esophageal perforation on the upper part of his esophagus. His lung became infected due to the perforation. He suffered a serious complication that led to his right lung pleural thorax cavity almost collapsing. He was given conservative treatment for eight days for the esophageal perforation. This treatment failed and an emergency chest operation was performed on the plaintiff to control the infection and to prevent total lung collapse. The plaintiff filed this action claiming special and general damages against the first defendant for causing the esophageal perforation followed by the infection of his lung. The plaintiff claims that the second defendant is vicariously liable.

Held, dismissing the plaintiff's claim:

(1) The plaintiff alleged that the first defendant never explained to him that

the operation to remove the fish bone was risky. Dr Thomas Yau on the other hand testified that he has explained the risks to the plaintiff. In his clinic note of 23 December 1997, the first defendant noted that 'risk told and accepted'. He also testified that he had told the plaintiff that the operation was high risk but it would be crucial to remove the fish bone and it has to be done by surgery. His evidence on the explanation to the plaintiff that the operation was a high risk tallies with the contemporaneous document in his notes when his operation note states 'watch for esophageal perforation'. There is no reason to doubt Dr Thomas Yau's testimony on this point as they are documented in his clinical note as well as operation notes which are contemporaneous to the event then. Even if the court were to treat his evidence with suspicion, learned counsel for the plaintiff did not cross-examine him on this point. As such the evidence of Dr Thomas Yau remained unchallenged (see paras 5–7).

(2) In the circumstance of the present case there appears to be no alternative open to the plaintiff except to remove the fish bone by way of surgery. The expert witness testified that the fish bone cannot be removed by medication as alleged by the plaintiff in the statement of claim. The plaintiff has failed to produce any evidence to support such contention or to suggest that the operation conducted by the first defendant was unnecessary and alternative treatment was available (see para 8).

(3) None of the plaintiffs witnesses had established that it was the act or neglect of Dr Thomas Yau which had caused the perforation. Conversely, there is insurmountable evidence to state otherwise. The testimonies of Dr Ghandhiraj (PW1), the Cardiothoracic Surgeon in response to a question by learned counsel for the first defendant, Mr PS Ranjan, PW1 confirmed that a fish bone lodged in the esophagus can cause esophageal perforation. Dr Karim (PW5) explained that the risk of seeing an ENT a week after the fishbone is lodged could cause complication such as esophageal perforation, emphysema infection and could be serious. Dr Chang Keng Wee (PW6) testified that if a fish bone is lodged in the throat or esophagus for eight days without treatment it could lead to complications because the fishbone can work its way through the wall of the esophagus and cause perforation. The expert witness a Senior ENT Consultant Surgeon, Dr Yoong testifying as DW2 explained that a fish bone or a foreign body in the body for one week is unusually long and poses high risk to surgery. From all the testimonies it is clear that the esophageal perforation is caused by prolonged lodgement of the fish bone in the esophagus of the plaintiff (see para 10).

(4) The first defendant has breached the standard code of practice in prescribing oral tablet. The first defendant's attempt to justify his order of oral tablets on the basis that it could be taken without water is unacceptable. It is normal behaviour and common sense that tablets are to be taken with water. Besides, the first defendant did not specify in his order that such oral tablets are to be taken without water. No medical evidence is required on this point. The giving of Milo is a clear breach of standard code of practice by the nursing staff (see para 28).

(5) To succeed on this claim the plaintiff has to establish the causation effect of such breaches. In other words, there must be established by evidence that the oral tablets and the Milo are the probable or material cause of the lung infection suffered by the plaintiff. Undoubtedly, the plaintiff has established by evidence that the lung infection suffered by the plaintiff was directly due to the esophageal perforation. However, the plaintiff has not produced evidence to substantiate that the cause of the infection to his lung was attributable to these two incidents. The plaintiff though managed to establish the breach of code of practice by the first defendant in prescribing oral tablets and the giving of Milo but has failed to establish that these two episodes had contributed to the plaintiff's tragic condition (see paras 29–30).

(6) The plaintiff has raised a presumption that Milo and oral tablets could cause the infection in him but has failed to substantiate medically and legally the causative effects of these episodes to the state of the plaintiff. There is simply no evidence to proof causation and such the plaintiff's case remains unproved. Medical evidence established by the defendants in fact seems to give very little effect to the two episodes as the cause (see para 32).

[Bahasa Malaysia summary

Plaintif secara tidak sengaja telah tertelan tulang ikan. Beliau telah pergi berjumpa seorang pengamal perubatan awam yang mana menasihati beliau untuk berjumpa pakar Telinga, Hidung dan Kerongkong ('THK') seberapa segera. Seminggu selepas itu plaintif telah pergi menemui defendan pertama. Satu pembedahan untuk mengeluarkan tulang ikan telah dilakukan oleh defendan pertama pada hari yang sama. Plaintif telah dimasukkan ke hospital dan sepatutnya diletakkan sebagai 'Tanpa Melalui Mulut' selepas pembedahan. Walau bagaimanapun plaintif telah diberikan pil tablet melalui mulut dan diberikan minum Milo oleh jururawat kakitangan hospital. Kemudiannya didapati bahawa plaintif terdapat tembusan esofagus di bahagian atas esofagusnya. Paru-parunya telah dijangkiti kerana tembusan tersebut. Beliau menanggung komplikasi yang serius yang menjadikan paru-paru pleura toraks berlubang hampir gagal. Beliau telah diberikan

rawatan konservatif untuk lapan hari bagi tembusan esofagus. Rawatan ini telah gagal dan pembedahan dada kecemasan telah dilakukan terhadap plaintif untuk mengawal jangkitan dan untuk mencegah kegagalan paru-paru secara keseluruhannya. Plaintif telah memfailkan tindakan ini menuntut gantirugi am dan khas terhadap defendan pertama yang menyebabkan tembusan esofagus yang diikuti dengan jangkitan kepada paru-parunya. Plaintif menuntut bahawa defendan kedua adalah berliabiliti vikarius.

Diputuskan, menolak tuntutan plaintif:

(1) Plaintif mendakwa bahawa defendan pertama tidak pernah menjelaskan kepadanya bahawa pembedahan untuk mengeluarkan tulang ikan adalah berisiko. Dr Thomas Yau sebaliknya memberikan keterangan bahawa beliau telah menjelaskan risiko kepada plaintif. Dalam nota kliniknya bertarikh 23 Disember 1997, defendan pertama telah mencatatkan bahawa 'risiko telah diberitahu dan telah diterima'. Beliau juga memberikan keterangan bahawa beliau telah memberitahu plaintif bahawa pembedahan adalah berisiko tinggi tetapi ianya berkemungkinan sukar untuk mengeluarkan tulang ikan dan ianya perlu dilakukan melalui pembedahan. Keterangannya berkenaan dengan penjelasan kepada plaintif bahawa pembedahan adalah berisiko tinggi selaras dengan dokumen semasa dalam catatan beliau apabila catatan pembedahannya menyatakan 'berjaga-jaga dengan tembusan esofagus'. Tiada sebab untuk meragui keterangan Dr Thomas Yau berkenaan dengan perkara ini yang mana kesemuanya didokumentasikan dalam catatan klinik dan juga catatan pembedahan yang mana selaras dengan keadaan. Walaupun jika mahkamah memperlakukan keterangannya dengan sangsi, peguam plaintif yang terpelajar tidak memeriksa balas beliau atas perkara ini. Oleh itu keterangan Dr Thomas Yau kekal tidak dicabar (lihat perenggan 5–7).

(2) Dalam keadaan kes ini terdapatnya tiada alternatif yang terbuka kepada plaintif melainkan mengeluarkan tulang ikan melalui pembedahan. Saksi telah memberikan keterangan bahawa tulang ikan tidak boleh dikeluarkan melalui perubatan seperti mana didakwa oleh plaintif dalam pernyataan tuntutannya. Plaintif telah gagal untuk mengemukakan mana-mana bukti untuk menyokong dakwaan tersebut atau untuk mencadangkan bahawa pembedahan yang dilakukan oleh defendan pertama adalah tidak penting dan terdapatnya rawatan alternatif (lihat perenggan 8).

(3) Tidak seorang pun saksi plaintif telah membuktikan bahawa ianya adalah tindakan atau kecuaian Dr Thomas Yau yang menyebabkan tembusan. Secara akasnya, terdapatnya keterangan yang tidak dapat diatasi untuk menyatakan sebaliknya. Testimoni Dr Ghandhiraj (PW1),

Pakar Bedah Kardiotoraks dalam menjawab kepada soalan oleh peguam terpelajar defendan pertama, En PS Ranjan, PW1 mengesahkan bahawa tulang ikan yang tersangkut dalam esofagus boleh mengakibatkan tembusan esofagus. Dr Karim (PW5) menjelaskan bahawa risiko melihat THK seminggu selepas tulang ikan tersekat boleh menyebabkan komplikasi seperti tembusan esofagus, jangkitan emfisema dan boleh jadi serius. Dr Chang Keng Wee (PW6) telah memberikan keterangan bahawa, jika tulang ikan yang tersekat dalam kerongkong atau esofagus untuk lapan hari tanpa rawatan ianya boleh mengakibatkan komplikasi kerana tulang ikan boleh menembusi dinding esofagus dan menyebabkan tembusan. Saksi pakar seorang senior Perunding Pakar Bedah THK, Dr Yoong memberikan keterangan sebagai DW2 menjelaskan bahawa tulang ikan atau bendasing dalam badan untuk satu minggu di luar kebiasaan lamanya dan menimbulkan risiko yang tinggi kepada pembedahan. Melalui kesemua keterangan adalah jelas bahawa tembusan esofagus adalah disebabkan oleh tersekatnya tulang ikan yang terlalu lama dalam esofagus plaintif (lihat perenggan 10).

(4) Defendan pertama telah melanggar kod amalan yang standard dalam mempreskripsikan tablet melalui mulut. Defendan pertama cuba untuk menjustifikasikan arahan tablet melalui mulutnya atas dasar bahawa ianya boleh diambil tanpa air adalah tidak boleh diterima. Ianya adalah tindakan yang biasa dan kebiasaan bahawa tablet diambil dengan air. Lagipun, defendan pertama tidak menyatakan arahannya bahawa tablet melalui mulut tersebut perlu diambil tanpa air. Tiada bukti perubatan diperlukan atas perkara ini. Pemberian Milo adalah jelas perlanggaran kod amalan standard oleh jururawat (lihat perenggan 28).

(5) Untuk berjaya dalam tuntutan ini plaintif perlu membuktikan kesan penyebaban kemungkiran tersebut. Erti kata lain, perlu terdapatnya pembuktian melalui keterangan bahawa pengambilan tablet dan Milo melalui mulut adalah kemungkinan atau sebab utama jangkitan paru-paru yang dialami oleh plaintif. Tidak dinafikan, plaintif telah membuktikan melalui keterangan bahawa jangkitan paru-paru yang dialami oleh plaintif adalah secara terus disebabkan tembusan esofagus. Tetapi, plaintif tidak mengemukakan bukti kepada pengesahan bahawa sebab jangkitan kepada paru-parunya adalah berpunca daripada dua peristiwa ini. Plaintif, walau bagaimanapun dapat membuktikan perlanggaran kod amalan oleh defendan pertama dalam mempreskipsikan tablet melalui mulut dan pemberian Milo tetapi telah gagal untuk membuktikan bahawa dua peristiwa ini menyumbang kepada keadaan plaintif yang tragik (lihat perenggan 29–30).

(6) Plaintif telah menimbulkan satu anggapan bahawa pengambilan Milo dan tablet melalui mulut boleh menyebabkan jangkitan kepadanya

tetapi telah gagal untuk mengesahkan secara perubatan dan perundangan bahawa penyebab kesan daripada episod-episod ini kepada keadaan plaintif. Ini betul-betul tanpa keterangan untuk membuktikan penyebab dan oleh itu kes plaintif kekal tidak dibuktikan. Bukti perubatan yang dibuktikan oleh defendan, kelihatan memberikan kesan sungguh sedikit kepada dua episod tersebut sebagai penyebab (lihat perenggan 32).]

Notes

For cases on professional negligence, see 12 *Mallal's Digest* (4th Ed, 2005 Reissue) paras 1133–1206.

Cases referred to

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 (refd)
Bolitho v City Hackney Authority [1997] 4 All ER 771 (refd)
Caswell v Powell Duffryn Associated Collieries [1940] AC 152 (refd)
Dominic Puthucheary & Ors v Dr Goon Siew Fong & Anor [2007] 5 MLJ 552 (refd)
Dr Chin Yoon Hiap v Ng Eii Khoon & Ors and other appeals [1998] 1 MLJ 57 (refd)
Elizabeth Choo v Government of Malaysia & Anor [1970] 2 MLJ 171 (refd)
Foo Fio Na v Dr Soo Fook Mun & Anor [2007] 1 MLJ 593 (refd)
Hunter v Hanley [1955] SC 200 (SCOT) (refd)
Whilsher v Essex Area Health Authority [1988] 1 All ER 871 (refd)

Rajan (Surinder Kaur with him) (Su, Raj & Co) for the plaintiff.
PS Ranjan (Manmohan Singh with him) (PS Ranjan & Co) for the first defendant.
S Murali (Khoo & Sidhu) for the second defendant.

Rohana Yusuf J:

[1] The plaintiff claimed for special and general damages against the first defendant, a medical consultant for causing 'esophageal perforation' on the upper part of his esophagus followed subsequently by infection of his lung. The second defendant is said to be vicariously liable for the claim.

BRIEF FACTS

[2] The brief facts of the case are as follows. The plaintiff had on 15 December 1997 accidentally swallowed a fish bone. He went to see Dr Abdul Karim bin Abdul Rahman (PW5) a general practitioner, on the day itself. Two days later, on 17 December 1997 he went back to the same doctor as the fish bone was still lodged in his esophagus. He was advised to see an

Ear, Nose and Throat Specialist (ENT) immediately. About one week later on 23 December 1997, the plaintiff went to see the Dr Thomas Yau Pak Chenk the first defendant an ENT Specialist at the Taman Desa Medical Centre. An operation to remove the fish bone was performed by the first defendant on that same day. Thereafter, the plaintiff was admitted to the same hospital. He was supposedly put on Nil Orally after the operation. He was however given tablets orally on the alleged order of Dr Thomas Yau. He was also given a drink of Milo by the nursing staff of the hospital. On 24 December 1997 a test performed on him showed that he has 'esophageal perforation' on the upper part of his esophagus. After that his lung became infected due to the perforation. He suffered a serious complication that led to his right lung pleural thorax cavity almost collapsing. At the Taman Desa Medical Centre he was given conservative treatment for eight days for the esophageal perforation. That treatment failed. On 2 January 1998 he was transferred to Gleneagles Medical Centre (GEMC). An emergency chest operation was performed on him by a Thoracic and Cardiovascular Surgeon Dato' Dr Ghandhiraj a/l Somasundram (PW1) to control the infection and to prevent total lung collapse.

THE PLAINTIFF'S CLAIM

[3] From the pleading I can sum up plaintiff's allegation against the defendants as follows:

(a) that Dr Thomas Yau had failed to inform him of the risks of the operation to remove the fish bone;

(b) that by the operation he had negligently caused the perforation of the oesophagus to occur;

(c) that he had instructed the nurses to allow the plaintiff to consume food and drinks after the operation;

(d) that conservative treatment was unnecessarily prolonged;

(e) that the fish bone could have been removed with medication; and

(f) that the second defendant should be held vicariously liable for the negligence of the first defendant and the nursing staff.

ISSUES

[4] I would like to treat the plaintiff's allegation of negligence into two separate parts. The first part is on the esophageal perforation. Here the issue to be determined is whether the first defendant is negligent in failing to explain the risk of the operation to the plaintiff or if he has performed an unnecessary operation, or has caused esophageal perforation in the upper part

of the plaintiff's esophagus in the course of the operation. Whether or not the first defendant has caused the esophageal perforation, the second part on the allegation of negligence is related to the infection that had occurred in the plaintiff's right lung pleural thorax cavity following the esophageal perforation. The issue to be determined here is whether the first defendant in his after care post-operation had caused the infection to the lung of the plaintiff to occur as a result of his failure to follow the standard code of practice specifically NIL ORALLY, when he prescribed oral tablets to be given to the plaintiff. The other issue is whether the feeding of Milo by the nursing staff of the second defendant had caused the infection to the plaintiff's lung. Under both circumstances the issues for determination are whether the act or neglect of Dr Thomas Yau or the nursing staff or both had caused the infection to the plaintiff. If so, then it will render the first defendant liable to the claim of the plaintiff and the second defendant to be vicariously liable for the same.

ESOPHAGEAL PERFORATION

Risk of operation unexplained

[5] The first issue raised by the plaintiff that needed determination under this part is the allegation of not explaining the risk involved by the first defendant. The plaintiff alleged that the first defendant never explained to him that the operation to remove the fish bone was risky. The plaintiff, Mr Lechemanavasagar a/l S Karuppiah (PW2) testified that on 23 December 1997 he went to the Taman Desa Medical Centre. After an X-ray was performed on him he was referred to Dr Thomas Yau. He was told by the first defendant that the operation for removing fish bone was a simple one and he would be able to return home a few hours after the operation. He agreed to undergo the surgery to remove the fish bone and did not even inform his family about it as he was under the impression that it was a simple surgery.

[6] Dr Thomas Yau on the other hand testified that he has explained the risks to the plaintiff. In his clinic note of 23 December 1997 (as appeared in B–113), the first defendant noted that 'risk told and accepted'. He also testified that he had told the plaintiff that the operation was high risk but it would be crucial to remove the fish bone and it has to be done by surgery. His evidence on the explanation to the plaintiff that the operation was a high risk tallies with the contemporaneous document in his notes when his operation note states 'watch for esophageal perforation'.

[7] There are now two conflicting bits of evidence before me on this issue. From these evidences I believe that the first defendant had explained the risk to the plaintiff because his evidence is supported by the contemporaneous document produced. At the onset the first defendant was quite mindful of the

A complication that would ensue (at pp 132 and 133 bundle B). I have no reason to doubt Dr Thomas Yau's testimony on this point as they are documented in his clinical note as well as operation notes which are contemporaneous to the event then. Even if I were to treat his evidence with suspicion, learned counsel for the plaintiff did not cross-examine him on this
B point. As such the evidence of Dr Thomas Yau remained unchallenged. Learned counsel for the plaintiff Mr Raj an cited in authority the Federal Court case of *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593 to support his case. In that case the Federal Court in deliberating the scope of a doctor's duty states that it departed from the *Bolam Principle* and held that
C a medical practitioner is duty bound to inform the patient of the risk involved in any proposed treatment to enable the patient to elect to proceed with the treatment or not. It would appear from this Federal Court decision that even if a doctor in the course of giving treatment to the plaintiff has followed the standard procedures acceptable to a group of medical practitioners and would
D have passed the Bolam test, he is not discharging his duties if he fails to explain the risk to the patient to enable the patient to elect to proceed with the treatment or not.

E **[8]** In the circumstance of the present case there appears to be no alternative open to the plaintiff except to remove the fish bone by way of surgery. One piece of medical evidence surfaced in the trial through the expert witness Dr Yoong Fook Ngian (DW2) a Consultant ENT Surgeon and the Director at Ipoh Specialist Hospital. He testified that fish bone cannot be
F removed by medication as alleged by the plaintiff in the statement of claim. The plaintiff has failed to produce any evidence to support such contention or to suggest that the operation conducted by the first defendant was unnecessary and alternative treatment was available. In fact, all medical witnesses who had been questioned on this point concluded that the fish
G bone has to be removed by surgery. As such even if I have been wrong in my finding that the first defendant has explained the risk involved, I see no merit in the plaintiff's allegation on this point given the circumstances of the present case. Besides, counsel for the plaintiff has not submitted the relevance of his contention of unexplained risk in a case where election does not even
H arise. That apart, Dr Thomas Yau in his testimonies explained that it would be incorrect and unethical for him not to treat and remove the fish bone from the plaintiff because leaving the fish bone there would be even more devastating to the plaintiff.

I NEGLIGENCE: THE CAUSE OF PERFORATION

[9] On this point, the plaintiff's case was that the esophageal perforation in the plaintiff was caused by the treatment or the removal of the fish bone by Dr Thomas Yau during the operation. In his pleaded case on particulars of

negligence, the plaintiff alleged the failure of the first defendant to control the operation properly or reasonably or physically or with electrical gadgets used for the operation, in order to avoid injuries to the plaintiff. At the same time the plaintiff also alleged that the operation was unnecessary as fish bone can be treated with medication, (the issue which I had dealt with earlier).

[10] In order to succeed on this allegation the plaintiff has to prove that it was the first defendant who had caused the esophageal perforation in the plaintiff. The plaintiff however has made no attempt to prove this particular allegation. None of the plaintiffs witnesses had established that it was the act or neglect of Dr Thomas Yau which had caused the perforation. Conversely, I find insurmountable evidence to state otherwise. The testimonies of Dr Ghandhiraj (PW1), the Cardiothoracic Surgeon in response to a question by learned counsel for the first defendant, Mr PS Ranjan, PW1 confirmed that a fish bone lodged in the esophagus can cause esophageal perforation. Dr Karim (PW5) explained that the risk of seeing an ENT a week after the fish bone is lodged could cause complication such as esophageal perforation, emphysema infection and could be serious. Dr Chang Keng Wee (PW6) testified that if a fish bone is lodged in the throat or esophagus for eight days without treatment it could lead to complications because the fish bone can work its way through the wall of the esophagus and cause perforation. The expert witness a Senior ENT Consultant Surgeon, Dr Yoong testifying as DW2 explained that a fish bone or a foreign body in the body for one week is unusually long and poses high risk to surgery. His explanation was that with a foreign body lodged, the tissues around it become friable. Upon removal of the bone from the wall a hole will then develop. He further confirmed that from the available information (given to him in the present case), the esophageal perforation was caused by fish bone penetrating the esophagus. From all the testimonies it is clear that the esophageal perforation is caused by prolonged lodgement of the fish bone in the esophagus of the plaintiff.

[11] In relation to the operation done by the first defendant expert witness Dr Yoong also explained that the Laryngoscopy and Esophagoscopy performed on the plaintiff by the first defendant was necessary. Laryngoscopy was necessary to see the upper part of the throat and esophagoscopy to see the lower part. In an attempt to establish that Ryles tube could have caused the perforation, learned counsel for the plaintiff, Mr Raj an questioned Dr Yoong on whether insertion of Ryles tube will pass through the same area of the esophageal perforation. Dr Yoong explained that Ryles tube will go through the lament of the esophageal perforation and will bypass the perforation as it goes down. He also confirmed that during the entry the tube will either be in U or V shape and it will not aggravate perforation. Besides these testimonies, Dr Thomas Yau himself also explained that there was no active

bleeding, in the course of performing the operation to suggest that the removal of the fish bone was done in a rough manner. It is clear from all the testimonies above that esophageal perforation had developed as a result of the long delay to remove the foreign body and was not caused by the operation done on the plaintiff.

[12] The plaintiff owes the burden of proving the alleged negligence but has failed to do so. It is trite law that to succeed in a claim based on negligence the plaintiff bears the burden of proving that there is a breach of duty of care on the part of the defendant. I would like to refer to the case authority referred to me by the counsel for the first defendant in the Court of Appeal decision of *Dr Chin Yoon Hiap v Ng Eii Khoon & Ors and other appeals* [1998] 1 MLJ 57. In that case it was held that to succeed in a case based on negligence it is necessary to establish a breach of that duty of care which the law requires and the degree of want of care. The Court of Appeal further states that in relation to conduct of doctors the true test of establishing negligence in diagnosis or treatment on the part of the doctor is whether he has been proven to have failed such that no doctor of ordinary skill acting with ordinary care would be guilty of. The late Abdul Malik Ahmad JCA whilst delivering this judgment (citing with approval the cases of *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, *Caswell v Powell Duffryn Associated Collieries* [1940] AC 152, *Elizabeth Choo v Government of Malaysia & Anor* [1970] 2 MLJ 171, *Hunter v Hanley* [1955] SC 200 (SCOT)), has stated that the standard of care expected of a medical practitioner is that he is not required to exercise the highest or very high standard, but only a fair and reasonable standard of care and skill in the treatment of his patients. Thus a doctor cannot be held negligent if he follows what is the general approved practice in the situation with which he is faced.

[13] I do not find any departure from an ordinary care or treatment given by Dr Thomas Yau in this case. The plaintiff here has failed to establish any breach of such duty against the first defendant. The first defendant has followed the standard practice expected of him. Thus the plaintiff's allegation on this head of claim must fail.

NEGLIGENCE: CAUSING INFECTION

[14] Having found that esophageal perforation was not caused by the first defendant, the next issue for my determination is whether the act or neglect of the first defendant and other employees of the second defendant, post operation had caused the infection to the lung of the plaintiff to such a magnitude that it compelled him to undergo another surgery at the GEMC. I would like to state at the outset that despite my above findings that esophageal perforation resulted from no negligence on the part of the first

defendant, both the first and second defendant could still be liable for the infection suffered by the plaintiff to his lung resulting from the esophageal perforation, if the plaintiff can prove that the act or neglect of the first and the second defendant's other agent had caused the infection and further complications that had befallen the plaintiff.

[15] The plaintiff has established through the testimonies of plaintiff's expert PW1, Dr Ghandhiraj that when the plaintiff was brought to GEMC the plaintiff has pleural collection in the chest with the collapse of the right lung, secondary to the esophageal perforation. Dr Ghandhiraj had to perform an emergency operation on him immediately to save his life. It has been determined factually and medically that the esophageal perforation had caused the infection in the plaintiff's chest cavity, subsequently causing a total collapse of the plaintiff's lower and middle portion of the lung and partial collapse of the upper portion due to the presence of abundant pus.

THE PLAINTIFFS CASE

[16] The plaintiff's case was that the first defendant knew that the plaintiff was carrying a high risk of esophageal perforation which the first defendant appreciated at the time he saw the plaintiff on 23 December 1997. The plaintiff alleges that the first defendant had adopted a relaxed and nonchalant attitude in treating the plaintiff. The plaintiff contends that this behaviour of the first defendant was first shown when the first defendant had informed the plaintiff that the procedure for removing fish bone was simple and maintained throughout the treatment period that the condition of the plaintiff was not serious.

[17] The plaintiff then alleged that the standard practice to be adopted in a case such as this is to put the plaintiff strictly on 'nil orally' after the operation, before esophageal perforation is clinically determined. The plaintiff relied on the expert evidence by Dr Chang Keng Wee (PW6), the Consultant Surgeon, as well as the evidence of the expert witness Dr Yoong (DW2) both of whom testified that the plaintiff should be kept 'nil orally' after an operation of such nature. The accepted practice according to the counsel for the plaintiff, Mr Rajan, is to first confirm and rule out esophageal perforation by gastro test before oral feed can be given. Counsel for the plaintiff alleged that the treatment given to the plaintiff was not in line with that standard code of practice when two events occurred. The first event was, even though the plaintiff complained of chest pain (which was already communicated to the first defendant) plaintiff was given ponstan and penglobe (as appeared in the nurse's notes at B–145) upon instruction of the first defendant. The tablets according to the counsel for the plaintiff must be presumed to have been given to the plaintiff with a glass of

water. Mr Rajan submitted that the first defendant tried to suppress the fact that he ordered oral tablets when in his testimony he testified that he was not sure if tablets were given at all.

[18] The tablets were given according to the plaintiff, despite the plaintiff's continuing complain of muscle spasm over the chest region and neck swelling. On 24 December 1997, the second defendant's employee (the nurse on duty), had given the plaintiff, a cup of Milo at 9am on that day. Thereafter further complications were suffered by the plaintiff including neck swelling. The first defendant who subsequently diagnosed the plaintiff with esophageal perforation had decided to give a conservative treatment for esophageal perforation, that is, by administering doses of antibiotics.

[19] The plaintiff further alleged that the giving of oral tablets which necessitates consumption of water and the giving of Milo by the nurse were made against normal practice of 'nil orally'. On that basis the counsel for the plaintiff submitted that Milo was one of the causes of infection, if not the primary cause. Even though expert testimonies of DW2 and of other medical witnesses agreed that saliva can also cause infection, counsel for the plaintiff contended that it would not absolve the negligence of the first defendant and the second defendant for failing to observe the basic code of practice.

THE DEFENDANT'S CASE

[20] The defendant's case was that, operation took place at 6pm on 23 December 1997. Dr Thomas Yau said after the operation, he gave order 'nil orally' to be observed. His post-operative order is recorded as:

> Sips to wet lips tonight — *nothing by mouth* Hartmans solution intravenously at lOOccs/hour call. Dr Yau stat for chest pain and high fever. *Clear liquids* in the morning if *no chest pain or fever.*
>
> Medications: Stemetil 12.5 mg IM 8 hourly prn for nausea/vomit Dormicum 7.5 mg orally at night prn *if no fever/chest pain*. Penglobe 40 mg twice daily if no fever/chest pain. Penglobe 400 mg twice daily if no fever/chest pain. Ponstan 1-2 capsules 4 hourly for pain *if no chest pain* or fever
>
> (emphasis added)

[21] The first defendant explained that his post operative order is clear that the plaintiff was to be put on 'nil orally'. He also states that he was to be called immediately if chest pain and high fever developed in the plaintiff. Chest pain according to him and also as per the testimony of the DW2 is an indication of a suspicion of esophageal perforation. DW2 also said the plaintiff should be given clear water in the morning as a test dose for

esophageal perforation. Oral tablets can only be given if there was no chest pain or fever. In the nurse's note the two incidents were recorded (as appear in bundle B at pp 145) as follows:

23 Dec 1997—2200

— in pain over lumba region — tab. Postan and penglobe given.

24 December 0900

— patient nursed prop-up. Unable to tolerate Milo coughing.

From the testimonies and the above record I have no doubt that the plaintiff had been given tablets orally at 2200 on 23 December 1997 and also Milo at 0900 on 24 December 1997.

[22] The first defendant explained that his order for oral medication was made subject to the plaintiff not having fever or chest pains. His order also includes the giving of clear liquid if there was no chest pain in the morning. The first defendant tried to justify that even if his order to be given tablet orally was made wrongly, it will not defy nil orally because tablets can be taken without water, or with very little water. He however maintained that his instruction for tablets was only applicable if 'there is no pain or fever' as stated in his post operative instruction. Mr PS Ranjan submitted for the first defendant that even if tablets were given orally it would not be the main cause of infection because swallowing of saliva which is inevitable in all cases raises the same risk.

[23] Mr PS Ranjan's contention was supported by DW2's testimony that saliva would be more harmful than water as saliva contains germs, though DW2 and DW1 differ on the amount of saliva consumed daily. DW1 states it should be 2500 cc whilst DW6 said it should be between 500 cc to 1000 cc depending on the person's state of hydration. In fact the testimony of DW2 supports the first defendant's case because according to DW2, clear water, if given with oral tablets is not likely to harm as it is non irritant.

[24] The giving of Milo, the first defendant says, was clearly against his order and it was done without his knowledge. On this issue, the expert witness DW2 testified that Milo could cause irritation. He further explained that as opposed to food and drink taken during the eight days before removal of the bone, it would not cause infection because when the bone is stuck to the wall of esophagus it will not leak, but once removed a hole is formed which becomes bigger and saliva will go into the perforation. He would however give Milo as a minor contributor to infection. To the second defendant's counsel's question DW2 answered that he would in the

circumstance treat Milo as a test dose albeit an unintentional one. He further explained that normally clear water would be administered as test dose instead.

[25] Learned counsel for the first defendant submitted that the plaintiff had not pleaded in his statement of claim that oral tablets were given to the plaintiff. Consequently, the first defendant is deprived of pleading a specific defence on this issue. Both counsels for the defendants, Mr PS Ranjan and Mr Murali submitted that in both episodes the plaintiff had failed to establish the necessary causation against both defendants. This is because according to the first defendant's counsel, in a tort of negligence it is not sufficient for a plaintiff to prove that there is a breach of duty alone. The plaintiff must prove that such breach of duty has a causation effect on the damages suffered by the plaintiff. It was also the submission of the learned counsel for the second defendant that it is not enough for the plaintiff to show that the drink of Milo was one of the possible causes of infection, but he has to prove that it is the probable cause or probable material cause.

[26] Mr PS Ranjan, maintained that there was no breach of duty on the part of the first defendant both in the course of the operation and the post operation of the plaintiff that could render him liable to the claim of the plaintiff. He contended that the plaintiff has failed to discharge the required burden of proof in that he has not established any causation in both the oral tablets episode as well as the Milo episode in relation to the infection to the plaintiff's lung that merits another surgical intervention and that had brought the plaintiff to his current medical position. Mr. Murali also contended the same ground in his submission on behalf of the second defendant.

FINDING

[27] Having heard both the submissions of learned counsel for the plaintiff as well as learned counsels for both defendants, the main issue for my determination on this part of the plaintiff's claim is this. Whether the act or neglect of the first defendant and other employees of the second defendant during post operation had caused the infection to the lung of the plaintiff, to a magnitude that has caused him to undergo another surgery at the GEMC. To make that final determination, I will first examine if the first defendant is in breach of his standard code of practice in prescribing oral tablets to the plaintiff. If the answer is yes, the next question before me would be, does that taking of oral tablets cause the kind of infection to the plaintiff so as to render the first defendant liable. Similarly, the other issue for determination will be whether the giving of Milo is in breach of the code of practice or in breach of the order of the first defendant and had caused the same infection to the

plaintiff. If the answers to all these questions are in the positive then the second defendant would be held vicariously liable for the claim of the plaintiff.

[28] My first task is to determine whether the instruction to give the oral tablet by the first defendant, and the Milo given by the employee of the second defendant, are in breach of the standard code of practice to be adopted by the defendants in a case of 'nil orally'. Dr Thomas Yau maintained that the prescription of oral tablets by him was made subject to the plaintiff not showing chest pain or fever. The expert witness Dr Yoong in the examination-in-chief by Mr PS Ranjan commented that there was evidence that Dr Thomas Yau was looking out for esophageal perforation and normally in such a situation, the nurse who gave water should be aware of it. He also stated in the examination-in-chief that 'generally in nil by mouth we will give injection and not tablets if medication is necessary'. In cross-examination, DW2 confirmed that taking tablets with a glass of water will be contrary to nil orally. Based on these testimonies I find that the first defendant has breached the standard code of practice in prescribing oral tablet. I cannot accept the first defendant's attempt to justify his order of oral tablets on the basis that it could be taken without water. It is normal behaviour and common sense that tablets are to be taken with water. Besides, the first defendant did not specify in his order that such oral tablets are to be taken without water. I do not require any medical evidence on this point. The giving of Milo is a clear breach of standard code of practice by the nursing staff.

[29] Having found the defendants to be in breach of the standard code of practice, I then went on to examine whether such breaches were the causes of the infection. To succeed on this claim the plaintiff has to establish the causation effect of such breaches. In other words, there must be established by evidence that the oral tablets and the Milo are the probable or material cause of the lung infection suffered by the plaintiff. Undoubtedly, the plaintiff has established by evidence that the lung infection suffered by the plaintiff was directly due to the esophageal perforation. However, the plaintiff has not produced evidence to substantiate that the cause of the infection to his lung was attributable to these two incidents. The earlier cited Appeal Court decision, in *Dr Chan Yoon Yip v Ng Eu Khoon* is a clear authority on this point. In that case a claim was made against the doctor for giving excessive oxygen to a premature born plaintiff and for failure to inform the parents of the possibility of loss of vision. On appeal, one of the grounds was that the trial judge erred on the issue of causation and that the tortuous act found by the trial judge did not cause injury to the plaintiff. Malik Ahmad JCA referred to the case of *Whilsher v Essex Area Health Authority* [1988] 1 All ER 871 and cited it with approval, when he said:

A … where a plaintiff's injury was attributable to a number of possible causes, one of which was the defendant's negligence, the combination of the defendant's breach of duty and the plaintiff's injury did not give rise to a presumption that the defendant had caused the injury. Instead, the burden remained on the plaintiff to prove the causative link between the defendant's negligence and his injury,...

B

[30] On this point the expert witness Dr Govindaraj (PW2) explained that infection in the plaintiff's lung was a result of esophageal perforation. He also stated that there had been leakage secretion from mouth and pharynx into the chest cavity. Secretion from the mouth according to him contains bacteria C whilst the chest cavity is sterile, but once contaminated it could stimulate the infective process. As to how long the infection in the chest cavity takes to develop to such magnitude (as in the plaintiff's case here), it is relative. The first defendant testified that upon the occurrence of esophageal D perforation, various factors can lead to infection. The first defendant's testimony was confirmed by the expert evidence of DW2 who said that in the circumstances of the present case, infection could be caused by the Milo episode as well as the swallow of saliva. According to him, saliva contains bacteria which cause infection. From all the testimonies before me I cannot E form a definite conclusion that the giving of tablets or the Milo had indeed been the cause of the infection. The plaintiff though managed to establish the breach of code of practice by the first defendant in prescribing oral tablets and the giving of Milo but has failed to establish that these two episodes had contributed to the plaintiff's tragic condition. On this issue, the decision of F the Appeal Court above had adopted the decision of the English case of *Wilsher*. In *Wilsher*, the plaintiff's infant was born prematurely. He suffered from various illnesses, one of which was oxygen deficiency. A catheter which was supposed to be inserted into the artery was twice inserted into the vein instead. On both occasions the plaintiff was given excess oxygen. Later the G plaintiff was discovered to have been suffering from an incurable condition of the retina resulting in near blindness. Evidence adduced showed that the retinal condition could have been caused by excessive oxygen. It was also testified that such condition occurred too in premature babies who were not given oxygen, but suffered from the other five conditions which had also H afflicted the plaintiff in that case. The plaintiff's case against the hospital for negligence, alleging that retinal condition was caused by excess oxygen failed because the medical evidence produced at the trial was not conclusive whether excess oxygen had caused or materially contributed to plaintiff's retinal condition.

I

[31] I also note that the trial judge in *Wilsher* had made a finding of negligence on the hospital for failing to take precautionary steps to prevent excess oxygen being administered to the plaintiff. The trial judge went further to hold that the burden lay on the defendant to show there was no breach of

duty and to show that damage did not result from that breach. At the House of Lords, Lord Bridge after reviewing the various case authorities reaffirmed the principle that the onus of proving causation lies with the pursuer or plaintiff.

[32] Back to this case the expert witness in fact testified that if clear water were used to consume the tablets it is a non-irritating substance and one table spoon of water if swallowed will not go through perforation. According to him most will go through the esophagus and only a 'tiny little bit' will go through the perforation. On the Milo episode in cross-examination by Mr Murali, DW2 even responded that it could be treated as a test dose. Unlike the judge in the Wilsher's case I am not faced with any expert's conflicting evidence on the causation attributed to the oral tablets or the Milo. I am faced with no evidence to link the two episodes to the infection suffered by the plaintiff. The plaintiff has raised a presumption that Milo and oral tablets could cause the infection in him but has failed to substantiate medically and legally the causative effects of these episodes to the state of the plaintiff. There is simply no evidence to proof causation and such the plaintiff's case remains unproved. Medical evidence established by the defendants in fact seems to give very little effect to the two episodes as the cause.

[33] The latest decision of the Court of Appeal in *Dominic Puthucheary & Ors v Dr Goon Siew Fong & Anor* [2007] 5 MLJ 552 is another case in point. Gopal Sri Ram JCA held that the plaintiff in that case has failed to establish causation. He compared Wilsher's decision where there were conflicting evidence as to the cause of damages but in the above case he says the element of causation was missing. The facts of the case were as follows. The defendant was alleged to have failed to diagnose the plaintiff as a spinal injury case and the failure to treat the plaintiff for hypovolaemic shock had caused the plaintiff to suffer cardio respiratory arrest leading to his death. Upon examination of evidence before the court it was held that no causation was established that it was the defendant's failure that had caused the deceased to suffer cardio respiratory arrest, and the plaintiff's appeal failed.

[34] It is therefore my finding that even though the two episodes amount to breaches of code of practice for a nil orally patient by the first defendant and the nursing staff, but no evidence was offered by the plaintiff to prove the causation effect of such breaches.

CONSERVATIVE TREATMENT

[35] On the conservative treatment of the plaintiff, learned counsel for the plaintiff alleged that Dr Thomas Yau has failed to appreciate the gravity or the

seriousness of the plaintiff's condition when throughout his stay he has been suffering from chest pain and breathing difficulties. It was his submission that the Dr Thomas Yau had failed to give proper treatment or failed to refer the plaintiff to a cardiothoracic surgeon since chest cavity is not his area of expertise. Thus when the plaintiff was transferred to GEMC he was found by PW1 to be toxic, in poor hydrated condition, his chest cavity was infected by dangerous bacteria called klebsilia and at the stage of severe fulminate infection of the chest. Mr Rajan further contended that Dr Thomas Yau had failed in his duty by waiting till such deterioration had set in, and only after being confronted by the plaintiff's brother (PW4) decided to transfer the plaintiff to GEMC.

[36] Dr Thomas Yau explained why he adopted the conservative treatment in treating the esophageal perforation. He decided that conservative treatment should be undertaken before a surgical intervention. He ordered the giving of antibiotics by intravenous means and continued to monitor the condition of the plaintiff. The first defendant stated that conservative treatment instead of surgical intervention is always first adopted because as he puts it 'as surgeons we don't cut straight away'. In his experience he says it is worthwhile to treat perforation by esophageal suction for seven to nine days because there is a 50% chance of success. The plaintiff's condition was not deteriorating all the way as evidenced in the doctor's notes at pages B–97 to 107. After eight days, when the conservative treatment failed Dr Thomas Yau said he discussed with the family members of the plaintiff for him to be transferred to GEMC to be treated by a cardiothoracic surgeon.

[37] DW2 expert evidence supports the first defendant's practice of adopting a conservative treatment because in his observation it is the normal method undertaken. He also states in evidence that abscess does not occur in every perforation. DW2 states that whether conservative treatment should be undertaken or not, will depend on the patient's condition and if abscess was already present surgical treatment should be instituted early. He noted that no abscess was found initially following removal of fish bone by the first defendant. Abscess was found later in the chest cavity but not in the region of the esophagus.

[38] Basing on the above, I find that Dr Thomas Yau has not departed from the normal standard practice in adopting conservative treatment in this case. Following, the decision in *Hunter v Hanley* [1995] SC 200, and *Bolitho v City Hackney Authority* [1997] 4 All ER 771 which is often described as the *Bolitho* test Dr Thomas Yau has treaded on the well-worn path and there is no evidence to suggest that he deviated from the accepted practice in giving the plaintiff a conservative treatment for his esophageal perforation. Malaysian cases have adopted a similar approach as in Bolitho. The test in Bolitho can

be simply stated as this: a compliance with reasonable, respectable and responsible practice will more often than not absolve a doctor of liability. A similar test was adopted and followed in the Malaysian case of *Dr Chin Yoon Hiap v Ng Eu Khoon & other appeals*, and the earlier case of *Elizabeth Choo v Government of Malaysia & Anor* [1970] 2 MLJ 171.

[39] Basing on all the above reasons it is with much regret that I have to dismiss the plaintiff's claim with costs.

Plaintiff's claim dismissed.

Reported by Brendan Navin Siva